Exhibit H

Preference Beneficiary's Affidavit

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York
Great - West Healthcare Administered by CIGNA

CIGNA

IMPORTANT: This affidavit should be completed by a person who is a member of the first surviving class of the classes of beneficiaries described in questions 2, 3, 4, or 5 below who need only answer the questions up to and including the class of which he/she is a member. If none in those classes survives, then all questions must be completed by the executor or administrator of the insured's estate. If additional space is required, use reverse side showing number of question being answered.

Doug Kramer, Father, being first duly sworn, depose and says:
(Name of Person Making Affidavit and Relationship to Insured)

That Kristin Kramer, who died on 6.05.2017 was insured under
(Name of Insured) *(Insert Date of Death)*

Policy No. _____ In connection with the Group Life Insurance and/or Accidental Death
(Insert Full Policy Number)

and Dismemberment Policy of Company Cascade Fire District
(Insert Name of Group Policyholder - Employer)

I understand that in the absence of a beneficiary designated by the insured or surviving at the death of the insured, payment will be made in accordance with the terms of the applicable policy.

That for the purpose of inducing the insurer to recognize the person(s) named herein as potential beneficiaries entitled to payment under the policy, the undersigned does answer as follows and agrees to reimburse the insurer for any improper payment which is made based upon the information contained in this affidavit.

QUESTION	ANSWER (use back of form if needed)
1. Did the insured designate a beneficiary who predeceased him? ☐ Yes ☒ No *If "YES", give name, relationship and date of death.*	NAME RELATIONSHIP? / DATE OF DEATH
2. Did the insured leave a widow or widower surviving? ☐ Yes ☒ No *If "YES", complete as indicated.*	NAME ADDRESS (Street) (City) (State) (Zip Code) DATE OF BIRTH / SOCIAL SECURITY NUMBER DATE OF MARRIAGE TO EMPLOYEE / TYPE OF CEREMONY DATE OF DEATH (if applicable)
3. If the answer to Question 2 is "No", was the insured survived by any children (including illegitimate and legally adopted children and excluding stepchildren)? ☐ Yes ☒ No *If "Yes", give their names, addresses, dates of birth, social security numbers and dates of death if applicable. (Use reverse side if needed)*	NAME ADDRESS (Street) (City) (State) (Zip Code) DATE OF BIRTH / SOCIAL SECURITY NUMBER DATE OF DEATH (if applicable)
4. If the answers to Questions 2 and 3 are "No", did the parents of the insured or either of them survive him? ☒ Yes ☐ No *If "Yes", give names, addresses, dates of birth, social security numbers and dates of death. (Use reverse side if needed)*	NAME Doug Kramer ADDRESS (Street) (City) (State) (Zip Code) [redacted] DATE OF BIRTH 7-14-48 / SOCIAL SECURITY NUMBER [redacted] DATE OF DEATH (if applicable) n/a
5. If the answers to Questions 2, 3, and 4 are "No", was the insured survived by any brothers or sisters of whole or half blood? ☐ Yes ☐ No *If "Yes", give their names, addresses, dates of birth, social security numbers and dates of death if applicable. (Use reverse side if needed)*	NAME Robyn Kramer ADDRESS (Street) (City) (State) (Zip Code) [redacted] DATE OF BIRTH 12-14-53 / SOCIAL SECURITY NUMBER [redacted] DATE OF DEATH (if applicable) n/a

IMPORTANT: If answers to Questions 2, 3, 4 and 5 are "No", the foregoing must be completed in full by the executor or administrator of the insured's estate and accompanied by a certified copy of the court appointment of said executor or administrator.

Subscribed and sworn to before me this 22nd day of September 17

Jeanne R Clark
(Notary Public)

Douglas W. Kramer

Pittsburgh Claim Service Center
P.O. Box 22328
Pittsburgh, PA 15222-0328
1-800-238-2125 Toll Free

620789 Rev. 06/2009

JEANNE R. CLARK
NOTARY PUBLIC for the
STATE OF MONTANA
Residing at Billings, Montana
My Commission Expires
APRIL 29, 2020

OREGON HEALTH AUTHORITY
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

804626 (I.D. TAG NO.) | 136-2017-022921 (STATE FILE NUMBER)

TO BE COMPLETED BY FUNERAL FACILITY

Legal Name: First: Shasta	Middle: DelRae	Last: Kramer	Suffix:	Death Date: August 25, 2017
Sex: Female	Age: 43 years	Social Security Number: [redacted]	County of Death: Multnomah	
Birthdate: April 19, 1974	Birthplace: Billings, Montana		Was Decedent Ever in U.S. Armed Forces? No	
Residence: 525 NE Russell Street		City/Town: Portland		
Residence County: Multnomah	State or Foreign Country: Oregon	Zip Code + 4: 97212	Inside City Limits? Yes	
Marital Status at Time of Death: Never married	Spouse's Name Prior to First Marriage			
Father's Name: Douglas Kramer		Mother's Name Prior to First Marriage: Robyn L. Best		
Informant's Name: Robyn L. Kramer	Telephone Number: Not Available	Relationship to Decedent: Mother	Mailing Address: 3134 56th Street W, Billings, MT 59106	
Place of Death: Hospice Facility	Facility Name: Legacy Hopewell House Hospice			
Location of Death: 6171 SW Capitol Highway	City/Town or Location of Death: Portland	State: Oregon	Zip Code + 4: 97239-2649	
Method of Disposition: Cremation	Place of Disposition: Cascade Cremation Center	Location (City/Town and State): Tualatin, Oregon		
Name and Complete Address of Funeral Facility: Crown Memorial Center, Cremation & Burial; Portland; 832 NE Broadway Street, Portland, Oregon 97232				
Date of Disposition: TBD	Funeral Director's Signature: Electronically Signed — Jennifer L. Partenheimer	OR License Number: FS-0651		
Registrar's Signature: Jennifer A. Woodward	Date Received: August 29, 2017	Local File Number		
Amendment				

TO BE COMPLETED BY MEDICAL CERTIFIER

Was case referred to Medical Examiner? No	Autopsy? No	Were autopsy findings available to complete the cause of death?	Time of Death: 09:20 PM
CAUSE OF DEATH			
IMMEDIATE CAUSE: a. breast cancer metastatic to the liver, peritoneum, bones and brain			Approximate Interval: Onset to Death: years
Due to (or as a consequence of): b.			
Due to (or as a consequence of): c.			
Due to (or as a consequence of): d.			
Other significant conditions contributing to death:			
Manner of Death: Natural	If Female: Not Applicable		Did tobacco use contribute to death? No
Date of Injury	Time of Injury	Place of Injury	Injury at Work?
Location of Injury			
Describe how injury occurred			If transportation injury, specify:
Name and Address of Certifier: Jocelyn Cameron White — 815 NE Davis Street, Portland, Oregon 97232			
Name and Title of Attending Physician if Other than Certifier			Date Signed: August 29, 2017
Medical Certifier: Electronically Signed — Jocelyn Cameron White		Title of Certifier: M.D.	License Number: MD15704
Amendment			

20170900510

45 2CC (01/06)

I CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF THE ORIGINAL CERTIFICATE ON FILE OR THE VITAL RECORDS FACTS ON FILE IN THE OREGON CENTER FOR HEALTH STATISTICS.

September 01, 2017

DATE ISSUED: _____

Jennifer A. Woodward

JENNIFER A. WOODWARD, Ph.D.
STATE REGISTRAR

THIS COPY IS NOT VALID WITHOUT INTAGLIO SEAL IN BLUE AND BORDER

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE